New Jersey Department of Health and Senior Services

(For Submission to Local Health Department)

COMMUNICABLE DISEASE REPORT

(NOTE: Shaded areas are for Local Health Department Use Only.)

Name of Disease (Specify Organism)	Setting of Infection ☐ Sporadic Case ☐ Household Cluster ☐ Institutional Cluster ☐ Outbreak	State E No. **E-**	CDRS ID No.

Name of Patient *(Last)* *(First)* *(MI)*	Date of Birth ____ / ____ / ____ *Month* *Day* *Year*	Telephone Number ( )

Onset Date of Illness	Age	If <2 Years	Sex	Race	Ethnicity	Patient Pregnant?
____ / ____ / ____	____ Yrs.	____ Mos.	☐ M ☐ F ☐ Unk.	☐ White ☐ Black ☐ Amer.Indian/Alaskan ☐ Asian/Pacific Islander ☐ Unknown ☐ Other	☐ Hispanic ☐ Non-Hisp. ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Mailing Address (Include Name of Institution, if Applicable) *(Street)* *(City)* *(Zip)* *(County)*	Residence Location, if Different	Municipality Code of Residence

Occupation/School/Day Care ☐ Child Care Worker ☐ Day Care Attendee ☐ Health Care Worker ☐ Student ☐ Food Handler ☐ Other:	Place of Occupation/School/Day Care Site

Hospital Inpatient?	Admission date	Hospital	Deceased?
☐ Yes ☐ No ☐ Unknown	____ / ____ / ____ *Month* *Day* *Year*	*(Name)* *(City)* *(State)*	☐ Yes ☐ No ☐ Unknown

Treating Physician Name and Address, If Known	Telephone Number, If Known ( )	Case Status ☐ Possible ☐ Probable ☐ Confirmed

Has Patient Had Recent (in past 6 months):

A. Blood Transfusion? ☐ Yes ☐ No ☐ Unknown B. Renal Dialysis? ☐ Yes ☐ No ☐ Unknown

Was Travel Associated with Illness?	Country/State/County Visited	Date (Month/Day/Year) of Travel
☐ Yes ☐ No ☐ Unknown		From: To:

For Vaccine-Preventable Disease, Was Patient Vaccinated?	If Vaccinated, Vaccine Used	Date of Immunization
☐ Yes ☐ No ☐ Unknown		____ / ____ / ____ *Month* *Day* *Year*

SUPPORTING LABORATORY RESULTS

☐ No Specimens Collected ☐ Results Pending (Specify): _____ ☐ Unknown

☐ CULTURE POSITIVE
Specimen Collection Date: _____ Organism: _____ LAB: _____
Specimen Source: ☐ Blood ☐ CSF ☐ Stool ☐ Other: _____

☐ ANTIGEN TEST POSITIVE
(e.g. fluorescent antibody)
Specimen Collection Date: _____ Organism: _____ LAB: _____
Specimen Source: ☐ Sputum ☐ CSF ☐ Urine ☐ Other: _____
Test Done: ☐ LA ☐ FA ☐ DNA ☐ Other: _____

SEROLOGY / OTHER TESTS (Please specify test done)

Test Done	First Blood				Second Blood			
	Date	Pos.	Neg.	Titer	Date	Pos.	Neg.	Titer

Lab Performing Serology / Other Tests, if Known:

Supporting Clinical Information

Name of Person Submitting Report (Print)	Title	Telephone ( )

Name of Reporting Health Officer Representative	Name of Health Department	Date Initially Reported ____ / ____ / ____ *Month* *Day* *Year*